

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01905

Reg. Dist. No.

1902

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 1 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland, Maryland		c. LENGTH OF STAY IN 1b 15 hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural, Deer Park, Md.	
3. NAME OF DECEASED (Type or print)	First Richard	Middle Stabler	Last Browning
4. DATE OF DEATH	2	Month 15	Day Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 17th., 1875
9. AGE (in years at death) 83 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Game Warden (Retired)		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Richard Thomas Browning		14. MOTHER'S MAIDEN NAME Harriett Twigg	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Mr. Getty Browning, Raleigh, N. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRATHORACIC HEMORRHAGE			
DUE TO 825X Conditions, if any, which gove rise to immediate cause (a), stating the underlying cause last.			
(b) CRUSHED ANTERIOR CHEST WALL FOLLOWING AUTO ACCIDENT 16 hrs.			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) In auto accident a out 6:30 P. M. 2-14-59 near Deer Park, Md.	
20c. TIME OF INJURY 6:30 P.M. p. m. 2-14-59 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Md. Rt. 135		20f. (City or town) (County) (State) Nr. Deer Park, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE James H. Feaster, Jr., M. D.		DATE SIGNED 2-15-59	
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVED (Specify) Burial		22b. DATE THEREOF 2/18/1959	
22c. NAME OF CEMETERY OR CREMATORIUM Catholic Cemetery		22d. LOCATION (City, town, or county) (State) Oakland, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Leighton		ADDRESS Oakland, Md.	
24a. REC'D BY REGISTRAR FEB 19 '59		24b. REGISTRAR'S SIGNATURE Cinda S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1903 CERTIFICATE OF DEATH

01906

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) JENNINGS, MD		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00		e. STREET ADDRESS JENNINGS, MD	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Clara	Middle Ellen	Last Butler
4. DATE OF DEATH	Month FEB	Day 1	Year 1957
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 8, 1896
9. AGE (In years less birthday) 62 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. KIND OF BUSINESS OR INDUSTRY OWN HOME	12. BIRTHPLACE (State or foreign country) GARRETT Co, MD
13. FATHER'S NAME JESSE WILT	14. MOTHER'S MAIDEN NAME RACHAEL PLATTER	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Lloyd Bittinger Jennings, MD	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH INSTANTANEOUS	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X		Cerebral Vascular Accident	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. Arteriosclerotic Cardiovascular Disease		15 years	
DUE TO Diabetes Mellitus		15 years	
DUE TO Has had both lower limbs amputated (1957 + 1958)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. p. m.	Month October	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from October , 1957, to January , 1957, that I last saw the deceased alive on December 15, 1958 , and that death occurred at 1:30 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, State) 77 Oak Street, Oakland, Md.	
ACTUAL SIGNATURE Herbert H. Leighton, M.D.		DATE SIGNED 1/15/59	
PHYSICIAN'S NAME (Type) Herbert H. Leighton, M.D.		77 Oak Street, Oakland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/4/59	22c. NAME OF CEMETERY OR CREMATORIAL WILT	22d. LOCATION (City, town, or county) RURAL LONACONING, GARRETT Co MD
23. FUNERAL DIRECTOR'S SIGNATURE Don J. Newman, Grantsville, Md.	ADDRESS	24a. REC'D BY REGISTRAR FEB 5 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Evans

STATE OF CALIFORNIA
DEPARTMENT OF JUSTICE
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1904

CERTIFICATE OF DEATH

Reg. Dist. No.

01907

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kitzmiller		c. LENGTH OF STAY IN lb 33 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kitzmiller		d. STREET ADDRESS Center St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Center St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Mae	Middle Florence	Last Clark	4. DATE OF DEATH February	Month 7	Day Year 1959
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 22, 1882	9. AGE (In years last birthday) 76 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. DAYS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Abe Dawson				14. MOTHER'S MAIDEN NAME Jane Helmick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT John R. Clark		Address Kitzmiller, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 360X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus Arteriosclerosis							
INTERVAL BETWEEN ONSET AND DEATH 10 days 2 years 8 years							
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/15/1957 to 3/17/1957, that I last saw the deceased alive on 1/29/1957, and that death occurred at 3:35A.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Oakland, Oakland, Md.					
ACTUAL SIGNATURE A. E. Mance, M. D.		DATE SIGNED 7 Feb 1957					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-9-59		22c. NAME OF CEMETERY OR CREMATORIUM I.O.O.F. Cemetery		22d. LOCATION (City, town, or county) Elk Garden, W. Va. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE H. Leighton		ADDRESS Oakland, Md.		24d. REC'D BY REGISTRAR DATE FEB 10 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Knue	

CEMETECA DE DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1905

CERTIFICATE OF DEATH

01908

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,		c. LENGTH OF STAY IN 1b 4 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cuppett Nursing Home						e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Grace		First	Middle Edna	last Davis	4. DATE OF DEATH February	Month	Day 13,	Year 1959
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Nov. 29, 1878	9. AGE (In years last birthday) 80	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Louis Davis		14. MOTHER'S MAIDEN NAME Louisa Gleichman						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Cuppett Nursing Home		Address Oakland, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.1 CONGESTIVE HEART FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from JAN 1957 to FEB 1959, that I last saw the deceased alive on FEB 1959, and that death occurred at 4:50 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE E. I. Baumgartner, M. D. ADDRESS (Street, city or town, state) 25 Cedar St. DATE SIGNED 1/14/59								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/16/1959		22c. NAME OF CEMETERY OR CREMATORIAL Mt. Herman Methodist Cem., Cumberland, Md.		22d. LOCATION (City, town, or county) (State)		
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE FEB 19 59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

STATE OF CALIFORNIA
DEPARTMENT OF MOTOR VEHICLES
CERTIFICATE OF TITLE

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1906 CERTIFICATE OF DEATH

Reg. Dist. No. 01909

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia		b. COUNTY Tucker			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 7 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Davis		d. STREET ADDRESS Box 216			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Thomas		First	Middle	Lost	4. DATE OF DEATH Hammond	Month February	Day 6	Year 19 59	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-24-78		9. AGE (In years lost birthday) 80 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? America			
13. FATHER'S NAME Francis Marion Hammond			14. MOTHER'S MAIDEN NAME Louisa Cunningham Box 216 (Wife) Stella McCray Hammond, Davis, W. Va.						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> 16. SOCIAL SECURITY NO. <input type="checkbox"/> 17. INFORMANT <input type="checkbox"/>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Cerebral Hemorrhage INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis with hypertension 10 years (c) 10 years									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <input type="checkbox"/> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from 3/13/ , 19 56 , to 2/6/ , 19 59 , that I last saw the deceased alive on 2/5/ , 19 59 , and that death occurred at 11:15 AM , from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>Andrew E. Mance</i>	ADDRESS (Street, city or town, state) <i>Oakland, Md.</i>							DATE SIGNED <i>6 Feb 59</i>	
PHYSICIAN'S NAME (Type) Andrew E. Mance, M. D.	Oakland, Maryland								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 9, 1959	22c. NAME OF CEMETERY OR CREMATORIUM Davis Cemetery		22d. LOCATION (City, town, or county) Davis		(State) W. Va.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wayne C. Spiggle</i>	ADDRESS Davis, W. Va.	24a. REC'D BY REGISTRAR DATE FEB 11 '59		24b. REGISTRAR'S SIGNATURE <i>John S. Frank</i>					

BY ASSOCIATE-GENERAL COUNSEL TO THE STATE CHIEF JUSTICE

10/20/01 10:27:19 AM

20

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1907

CERTIFICATE OF DEATH

01910

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE West Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN lb 6 hrs. 48 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Terra Alta	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital		d. STREET ADDRESS 417 State St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Leola	Middle Mae	Last Kisner	4. DATE OF DEATH February 2	Month Year 1959
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 5, 1909	9. AGE (In years last birthday) 49 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Edward		14. MOTHER'S MAIDEN NAME Brenneman		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Agnes Frenneman	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4+ DUE TO Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Malignant Essential Hypertension (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Surgical history w/ chronic glomerulonephritis (left) Knee/marrow tract Disease					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Terra Alta	(County) W. Va. (State)
21. I certify that I attended the deceased from 1934, 19., to Feb 2, 1959, that I last saw the deceased alive on Feb 7, 1959, and that death occurred at 5:05AM, from the causes and on the date stated above.					
ACTUAL SIGNATURE Dr. Charles E. Smith, M.D.		ADDRESS (Street, city or town, state) Terra Alta, W. Va. DATE SIGNED Feb 14, 1959.			
22a. BURIAL, CREMATION, REMOVAL & BURIAL 2/5/59		22b. DATE THEREOF 2/5/59		22c. NAME OF CEMETERY OR CREMATORIUM Oak Grove Cemetery	
22d. LOCATION (City, town, or county) Route # 2, Terra Alta, W. Va.					
23. FUNERAL DIRECTOR'S SIGNATURE Mc. T. F. D. License No. A 6834		ADDRESS Terra Alta, W. Va.		24a. REC'D BY REGISTRAR FEB 4 '59	24b. REGISTRAR'S SIGNATURE Charles E. Smith

1. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1908 CERTIFICATE OF DEATH

Reg. Dist. No. 01911

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		b. COUNTY Garrett		
c. LENGTH OF STAY IN 1b 13 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Accident		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital		d. STREET ADDRESS		
e. IS RESIDENCE ON A FARM YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Elmer	Middle Edward	Last Lee	
4. DATE OF DEATH	Month February	Day 7	Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 5, 1910	
9. AGE (in years last birthday) 19 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Playford Lee	14. MOTHER'S MAIDEN NAME Marie F	Broadwater		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Playford Lee	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 196.7 DUE TO Paracoccidioides - pulmonary Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Primary left femur (c) DUE TO 3 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 23, 1951, to February 7, 1959, that I last saw the deceased alive on February 7, 1959, and that death occurred at 3:35 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Andrew E. Mance</i> M.D. ADDRESS (Street, city or town, state) <i>Oakland, Md.</i> DATE SIGNED <i>2/26/59</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/10/59	22c. NAME OF CEMETERY OR CREMATORIAL ACCIDENT	22d. LOCATION (City, town, or county) ACCIDENT GARRETT Co., MD. (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Don J. Newman, Gaithersburg Md.</i>		ADDRESS	24a. REC'D BY REGISTRAR FEB 13 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>



INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01912

1909 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY	Garrett	MARYLAND	STATE	Md.	COUNTY Garrett
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN Rural Friendsville	Life		TOWN Rural Friendsville	Rural Friendsville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS	(If rural give location)	
3. NAME OF DECEASED (First) (Middle) (Last)			4. DATE (Month) (Day) (Year)		
WILLIAM JACKSON LYTHE			4. DATE (Month) (Day) (Year)		
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. IF UNDER 1 YEAR Months Days Hours Min.
Male	White	Married	June 2m 1882	76 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	
Farmer retired			own Farm	Selbysport, Md.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
David Lytle			Latilda Summy		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
(If Yes, give war or dates of service)		-220-0570504 -		Mrs. Sarah Bowser, Friendsville, Md.	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
4. IMMEDIATE CAUSE (A) <u>Cardiovascular Failure</u>					
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u>					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Aging</u>					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>NONE</u>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
M.					
22. I hereby certify that I attended the deceased from <u>Nov. 19, 1958</u> , to <u>Feb. 19, 1959</u> , that I last saw the deceased alive on <u>Feb. 19, 1959</u> , and that death occurred at <u>9:00A.M.</u> from the causes and on the date stated above.					
SIGNATURE <u>John L. Linnell</u> M.D. ADDRESS (Street, city, town, state) <u>Friendsville Rd</u> DATE SIGNED <u>2/18/59</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	NAME OF CEMETERY OR CREMATORIUM		LOCATION (City, town, or county) (State)
BURIAL		5/1/59	FRIENDSVILLE		FRIENDSVILLE-GARRETT CO. MD.
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE	
MAR 3 '59		John S. Kline		John Newman, Friendsville, MD.	
DATE				ADDRESS	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01913

1910

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRELLIN	
3. NAME OF DECEASED (Type or print) CHARLES EMARAL		First MIDDLE MERSING	4. DATE OF DEATH FEBRUARY 6, 1959
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/16/1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY soft coal mines	11. BIRTHPLACE (State or foreign country) WEST VIRGINIA
13. FATHER'S NAME THOMAS MERSING		14. MOTHER'S MAIDEN NAME ROSALIE NUSBOUMER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-10-3709	17. INFORMANT (DAUGHTER) ANNA GRAHAM
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> or work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from olive on <u>Feb 1, 1959</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. <u>25 Alder St, Oaklnd, Md.</u> DATE SIGNED <u>2/16/59</u>	
ACTUAL SIGNATURE <u>H. J. Baumgartner</u>		PHYSICIAN'S NAME (Type) H. J. BAUMGARTNER	
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 2/9/1959	22c. NAME OF CEMETERY OR CREMATORIUM Ashby Cemetery
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Keighton</u>		24a. ADDRESS Oakland, Md.	24b. REG'D BY REGISTRAR FEB 9 1959 DATE
		24c. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

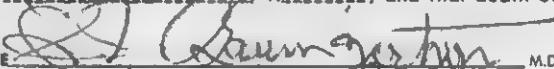
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

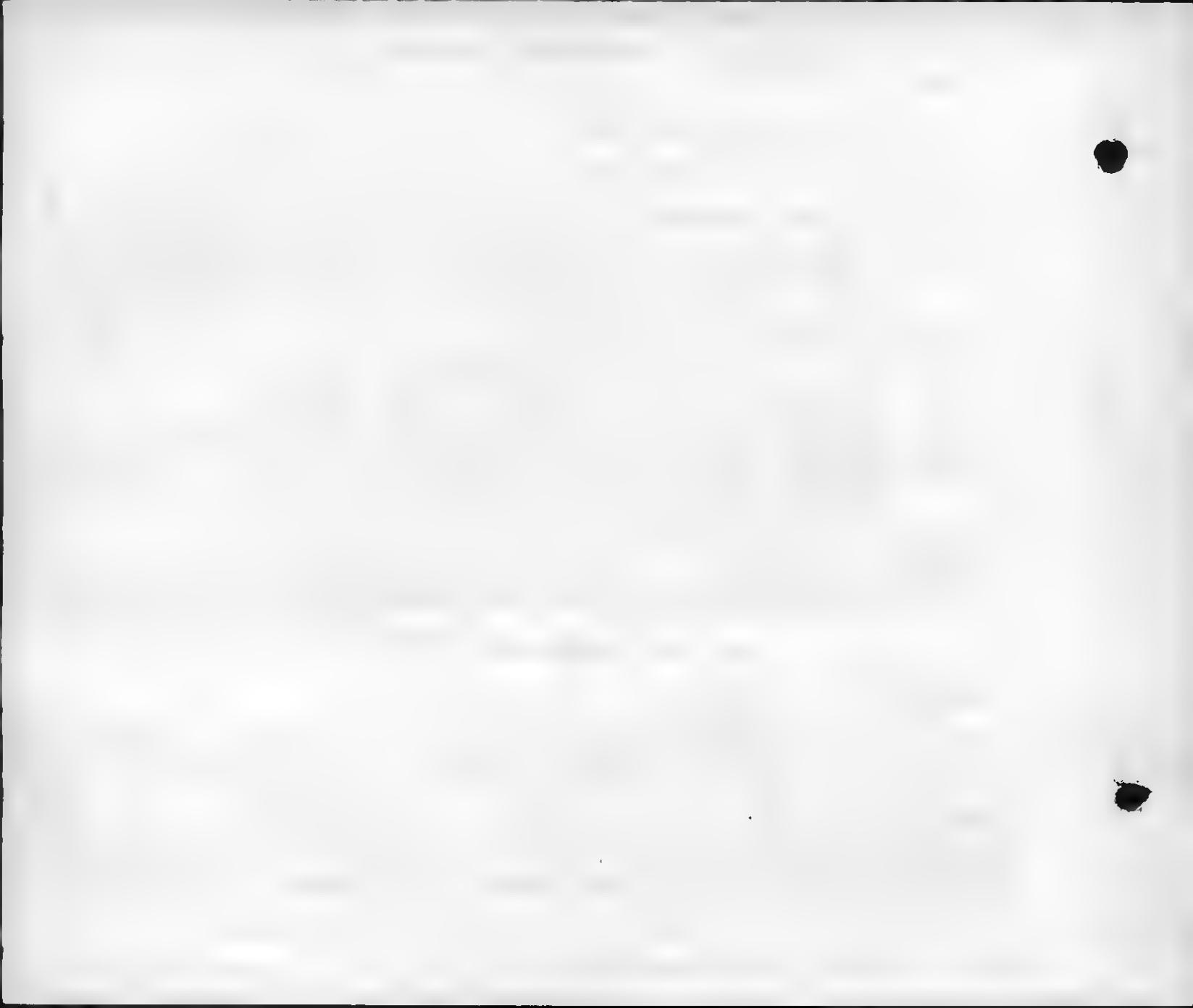
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1911

CERTIFICATE OF DEATH

Reg. Dist. No. 91911

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 63 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION vans Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jakien	
3. NAME OF DECEASED (Type or print) Anna		First Estelle	Middle Miller
4. DATE OF DEATH 2 1 1959		5. SEX Female	6. COLOR OR RACE White
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/05/1877	
9. AGE (in years last birthday) 82		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Frostburg Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Miller		14. MOTHER'S MAIDEN NAME Suzan Offutt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Thronton Deffinbaugh		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Kerebral Vascular Accident DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Hypertension DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) Oakland (State) Md.	
21. I certify that I attended the deceased from May , 1957, to February , 1959, that I last saw the deceased alive on Feb 13 , 1959, and that death occurred at 9:00 P. M. from the causes and on the date stated above. ACTUAL SIGNATURE  PHYSICIAN'S NAME (Type) E. I. Baumgartner, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) 1.1.11		22b. DATE THEREOF 2/15/1959	
22c. NAME OF CEMETERY OR CREMATORIAL Oakland Cemetery		22d. LOCATION (City, town, or county) Oakland (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE G. L. Miller		24a. REC'D BY REGISTRAR Feb 19 1959	
ADDRESS 61 Alder St., Oakland, Md.		24b. REGISTRAR'S SIGNATURE John K. K.	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1912

CERTIFICATE OF DEATH

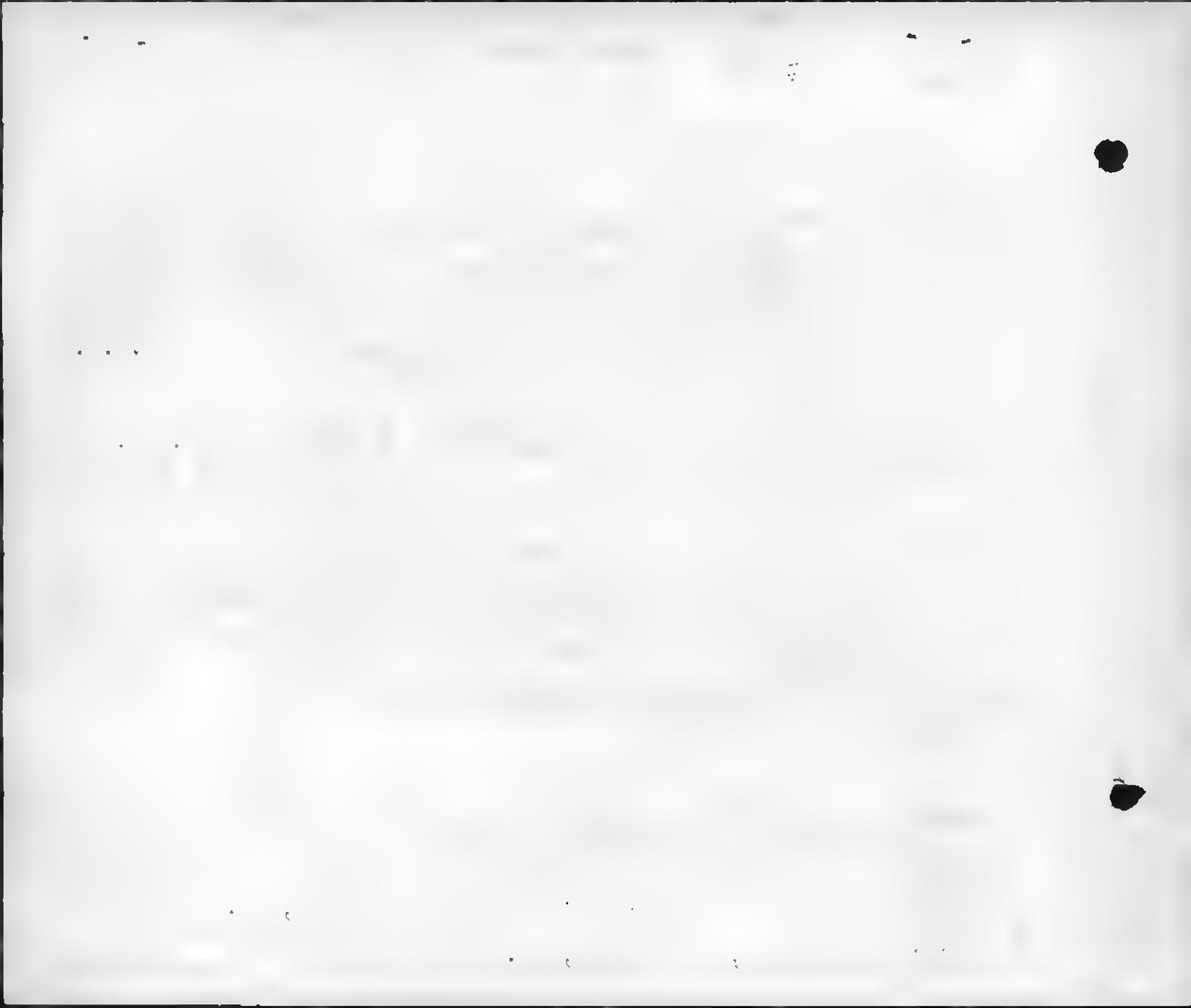
-01915

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
MARYLAND		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. Lake Lair		c. LENGTH OF STAY IN 1b 1 wk.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kiser Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nikay	
3. NAME OF DECEASED (Type or print)		First James	Middle Lester
4. DATE OF DEATH		Month 2	Day 25
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
7.1		8. DATE OF BIRTH 1/18, 1876	
9. AGE (In years last birthday) 01 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Industry	
10c. BIRTHPLACE (State or foreign country) Moscow		11. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Morgan		14. MOTHER'S MAIDEN NAME Liza Lee	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO NONE	
17. INFORMANT Kiser Nursing Home, Oakland, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 6 weeks	
19.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <i>Carcinoma of Neck</i> (c) <i>Metastases</i>		DUE TO causes	
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21. I certify that I attended the deceased from <u>2-16</u> , 19 <u>57</u> , to <u>2-23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2-23</u> , 19 <u>57</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <i>James H. Feltner Jr. M.D.</i> PHYSICIAN'S NAME (Type) <i>James H. Feltner Jr. M.D.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/27/1959	
22c. NAME OF CEMETERY OR CREMATORIUM Laurel Hill Cemetery		22d. LOCATION (City, town, or county) Moscow, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN		24a. REC'D BY REGISTRAR DATE FEB 27 '59	
ADDRESS , LONACONING, MD.		24b. REGISTRAR'S SIGNATURE <i>John J. Krause</i>	



INSTITUTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death.

THE bottom copy may be retained by the hospital or attending physician.
FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 (Rev. 10/68)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1913 CERTIFICATE OF DEATH

11916

Reg. Dist. No.

1. PLACE OF DEATH

COUNTY

GARRETT.

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)LENGTH OF STAY
(In this place)

TOWN

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

None

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE

Md

COUNTY

Garrett

CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWNSTREET
ADDRESS

Freudsville, Md

(If rural give location)

3. NAME OF
DECEASED
(Type or Print)

(First) (Middle) (Last)

GRACE R PHASKETT

5. SEX

6. COLOR OR
RACE

Female

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)10e. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)

House Keeper

10b. KIND OF BUSINESS
OR INDUSTRY

House Keeper

11. BIRTHPLACE (State or foreign country)

13. FATHER'S NAME

Rudolph Fauett

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unk.) (If Yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

No

17. INFORMANT & ADDRESS

John R. Phaskett, Freudsville, Md

18. MEDICAL CERTIFICATION

IMMEDIATE CAUSE

ANTECEDENT CAUSE(S)

DISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST.

(A) DUE TO

(B) DUE TO

(C) DUE TO

21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

22. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORI

LOCATION (City, town, or county)

(State)

ADDRESS (Street, city, town, state)

DATE SIGNED

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

26. DATE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~sever~~ carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1914

CERTIFICATE OF DEATH

11917

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 7 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Swanton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett Co. Memorial Hospital		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Arthur	Middle Galen	Last Sweitzer	4. DATE OF DEATH February 18	Month February	Day 18	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-11-37	9. AGE (In years last birthday) 21 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver	10b. KIND OF BUSINESS OR INDUSTRY State Forests & Parks	11. BIRTHPLACE (State or foreign country) Swanton, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Arthur Sweitzer	14. MOTHER'S MAIDEN NAME Amy Charlotte Harvey						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No	16. SOCIAL SECURITY NO. 214-36-6369	17. INFORMANT Wife (Alberta Sweitzer)	Address Swanton, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure INTERVAL BETWEEN ONSET AND DEATH 1 week							
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 196.7							
(b) Diffuse Sarcomatosis - & Metastases 1 year							
DUE TO (c) Osteogenic Sarcoma - Left Femur Known 21 Months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION, GIVEN IN PART I (d) 19. WAS AUTOPSY PERFORMED? Pathology Reports of left leg amputation & segmental lung resection YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 20.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month May	Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 77 Oak St. Oakland, Md.	(County) Oakland, Maryland	(State) Md.
21. I certify that I attended the deceased from May 1959 to Feb 18, 1959 , that I last saw the deceased alive on Feb 17, 1959 , and that death occurred at 8:25 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Herbert H. Leighton</i>	ADDRESS (Street, city or town, state) 77 Oak St. Oakland, Md.						DATE SIGNED 19 Feb 59
PHYSICIAN'S NAME (Type) Herbert H. Leighton, M. D.	Oakland, Maryland						
22a. BURIAL, CREMATION, BENEFITS (Specify) Burial	22b. DATE THEREOF 2/21/1959	22c. NAME OF CEMETERY OR CREMATORIUM George Cemetery			22d. LOCATION (City, town, or county) near Swanton, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Herb Leighton</i>	ADDRESS Oakland, Md.	24a. REC'D BY REGISTRAR FEB 24 1959			24b. REGISTRAR'S SIGNATURE Herb S. Mann		

STATE OF NEW YORK
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01918

Reg. Dist. No. _____

1. PLACE OF DEATH
a. COUNTY **Garrett** MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Oakland**

c. LENGTH OF STAY IN 1b **12 days**

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION **Garrett County Memorial Hospital**

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE **Maryland** b. COUNTY **Garrett**

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Oakland**

3. NAME OF DECEASED (Type or print) **Cora** First **Idella** Middle **Taylor** Last

4. DATE OF DEATH **February 28** Month **Day** **Year** **1959**

5. SEX **Female** **6. COLOR OR RACE** **white** **7. MARRIED** **NEVER MARRIED** **8. DATE OF BIRTH** **June 26, 1869** **9. AGE (In years
from birth)** **89** yrs. **10. IF UNDER 1 YEAR** **Months** **Days** **11. IF UNDER 24 HRS.** **Hours** **Min.**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **housewife** **10b. KIND OF BUSINESS OR INDUSTRY** **11. BIRTHPLACE (State or foreign country)** **West Virginia** **12. CITIZEN OF WHAT COUNTRY?** **U. S. A.**

13. FATHER'S NAME **Ames Jefferys** **14. MOTHER'S MAIDEN NAME** **Elizabeth Glover**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) **16. SOCIAL SECURITY NO.** **17. INFORMANT** **Address**
rs. T. P. Metheny, Terra Alta, W. Va.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] **INTERVAL BETWEEN
ONSET AND DEATH**

Part I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Cerebral Pneumonia - left lung** **2 weeks**
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) **Cerebral Vascular Accident** **Smooth**
(c) **Arteriosclerotic Cardiovascular Disease** **unknown**

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) **19. WAS AUTOPSY
PERFORMED?** **YES** **NO**

20a. ACCIDENT WAS UNDERLYING **20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)**

OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year **20d. INJURY OCCURRED** **20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)** **20f. (City or town)** **(County)** **(State)**

Hour o. m. **19** While at work Not while at work

21. I certify that I attended the deceased from **Feb 16, 1959, to Feb 28, 1959**, that I last saw the deceased alive on **Feb 27, 1959**, and that death occurred at **1:00** M, from the causes and on the date stated above.

ACTUAL SIGNATURE **Robert F. Leighter, M.D.** **ADDRESS (Street, city or town, state)** **DATE SIGNED**
77 Oak St. Oakland, Md. 28 Feb 59

PHYSICIAN'S NAME (Type) **m. Robert F. Leighter, M.D.** **Oakland, Md.**

22a. BURIAL, CREMATION, REMOVAL (Specify) **22b. DATE THEREOF** **22c. NAME OF CEMETERY OR CREMATORIUM** **22d. LOCATION (City, town, or county)** **(State)**

Removal & Burial 3/2/59 **3/2/59** **Terra Alta Cemetery** **Terra Alta, West Virginia.**

23. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** **24a. REC'D BY REGISTRAR** **24b. REGISTRAR'S SIGNATURE**

O. Watson **P. R. Watson, Terra Alta, West Virginia.** **DATE** **MAR 2 '59** **Arthur S. Knapp**

